STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008007	A. BUILDING: _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BLUFF NURSING HOME	4401 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure and Certification Investigation of Facility Reported Incident of 02-22-2024 IL170439	S 000		
S9999	Final Observations State Licensure Violations 1 of 3: 300.650d) d) The facility shall check the status of all applicants with the Health Care Worker Registry prior to hiring. These Regulations are not met as evidenced by: Based on interview and record review, the facility failed to ensure documentation of staff background checks were retained for 7 of 7 staff reviewed for background checks in the sample of 10. This has the potential to affect all residents in the facility. The findings include: The facility's CMS form 671 dated 3/6/24 showed 140 residents residing in the facility. During the annual survey on 3/5/24 to 3/7/24 staff personnel files for V27, V28, V29, V33, V34, V35, and V36 were reviewed. The files did not contain any record of the Illinois Sex Offender, DOC/Department of Corrections Sex Offender, DOC Inmate Search, DOC Wanted Fugitive, National Sex Offender, or the HHS/Health and Human Services OIG/Office of the Inspector General websites having been checked. On 3/6/24 at 1:30 PM, V13 (Human Resources)	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008007	A. BUILDING: _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BLUFF NURSING HOME	4401 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1	S9999		

stated she looks at the State Agency registry to ensure staff are eligible to work in the facility. The Winnebago County human resources office does a second check to see if any criminal activity was reported within the county. V13 said she does not verify any other websites, but it is possible that V14 does.

On 3/6/24 at 1:45 PM, V14 (Administrative Assistant) stated newly hired staff are checked in the healthcare registry for eligibility to work. They show up in the system if they have been fingerprinted in the past. The site shows if they are eligible to work or not. V14 said if they do not show up in the registry, they are sent to get fingerprinting done. V14 said she does not check any other website, but it is possible the Winnebago County HR/human resources department does, and she would verify that.

On 3/7/24 at 10:45 AM, V13 stated there was no other documentation related to the missing website checks. V13 said the registry checks are all that is put into the staff member's file. There is not documentation of the other six websites.

The facility's Background Investigations policy dated 10/16/23 states: "1. The Human Resources department will conduct all applicable background investigation(s) on each individual making application for employment with this company ..."

(C)
Statement of Licensure Violations 2 of 3:
300.610a)
300.1010h)
300.1210b)
300.1210c)
300.1210d)2)5)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008007	A. BUILDING: _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BLUFF NURSING HOME	4401 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008007	A. BUILDING: _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BLUFF NURSING HOME	4401 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		

resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

2) All treatments and procedures shall be administered as ordered by the physician.

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

These Regulations are not met as evidenced by:

Based on observation, interview, and record review the facility failed to identify a pressure injury prior to becoming a deep tissue injury, failed to obtain treatment orders for a new pressure injury, and failed to implement pressure relieving interventions for a resident with multiple pressure injuries for 1 of 7 residents (R117) reviewed for pressure injury in the sample of 31.

These failures resulted in R117 suffering a deep tissue injury to the right heel, a Stage 2 pressure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008007	A. BUILDING: _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BLUFF NURSING HOME	4401 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4	S9999		

injury to the right buttock, and a Stage 1 to the left lateral ankle.

The findings include:

R117's face sheet showed a 91-year-old male admitted to the facility on 2/9/24 with diagnoses of fracture of the right femur, weakness, polyneuropathy, heart failure, foot drop of the left and right feet, and chronic obstructive pulmonary disease.

On 03/05/24 at 12:21 PM, R117 was in a wheelchair in his room. There were ace wraps to both legs and feet. R117 had black shoes on his feet and his feet were on the foot pedals. V15 Certified Nursing Assistant-CNA and V12 CNA transferred R117 from the wheelchair to bed using a mechanical lift. R117 grimaced in discomfort during the transfer and his right leg rotated internally. V12 stated he fractured his right hip about 2 months ago and doesn't think he had surgery. V12 and V15 discussed if heel boots should be on when he was in the chair or in the bed. They were uncertain.

At 2:21 PM, V41, R117's son in law stated R117 fell at home on 2/4/24 and fractured his right hip. V41 stated R117 was not a candidate for surgery to repair the fracture due to the location of a plate in his leg. V41 stated R117 did not have any skin breakdown at the time of admission and cannot lift his leg.

03/06/24 12:25 PM, V2 Director of Nursing- DON stated if a new skin condition is found the nurse should obtain treatment orders and notify the provider and family. Pressure interventions should be put into place as soon as we can but getting a treatment started is more important. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008007	A. BUILDING: _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BLUFF NURSING HOME	4401 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5	S9999		

provider determines if the resident is referred to wound care. It's important that interventions are in place to avoid new injury and prevent worsening of current pressure wounds.

On 3/5/24, this surveyor requested to observe R117's wounds with wound rounds on 3/6/24. On 3/6/24, R117's wound round was completed when this surveyor arrived at the facility. On 3/6/24, this surveyor asked V42 wound doctor to speak with this surveyor when his rounds were done and before he left the facility. V42 left the facility without speaking to this surveyor.

At 1:08 PM, V2 assisted to observe R117's right heel wound. R117 was in bed with heel boots on, and both feet resting on the mattress. The offloading pillow was on the floor. V2 asked staff why the heels were not offloaded; they responded because he was eating. R117's right lateral heel had a non-blanchable red purple irregularly shaped area approximately the size of a quarter.

On 3/7/24 at 10:00 AM, V17 Unit Coordinator and V18 Registered Nurse-RN assisted to observe R117's left lateral ankle wound. R117 was in a wheelchair in his room. R117 had bilateral foam heel boots on with both feet resting on the foot pedals of the chair. There were inflatable boots with the heels open on the top shelf of the closet. V17 said those were from the hospital. R117's left foot was positioned outward allowing the left lateral ankle to rest on the heel boot. The left lateral ankle had non-blanchable red-purple area approximately the size of a dime.

R117's (late entry) skin concern notes effective 3/4/24 at 1:16 PM showed discoloration to bilateral heels. This note showed to float heels when in bed, ace wraps to bilateral legs, apply in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008007	A. BUILDING: _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BLUFF NURSING HOME	4401 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 6	S9999		

the morning and remove at night, medical doctor will be in the facility tomorrow to assess wounds and power of attorney gave consent for wound care to follow.

R117's 3/4/24 wound weekly observation tool showed a right heel suspected deep tissue injury measuring 3 centimeters (cm) X 4 cm. Float heels in bed/chair, wound care to see 3/6/24.

R117's wound doctor notes showed no mention of the heel wound being assessed. The note showed a Stage 1 pressure injury to the left lateral ankle measuring 2.5 X 0.6 cm and a Stage 2 pressure wound to the right upper medial buttock measuring 0.9 X 1.1 X 0.1 cm. This note showed to offload the wounds.

A 3/5/24 nursing note showed the medical doctor ordered heel lift boots while in wheelchair and a wedge when in bed.

R117's physician order sheet printed 3/6/24 at 1:10 AM showed orders dated 3/5/24 to float heels while in bed at all times and heel lift boots while up in wheelchair for pressure relief. An order for a gel dressing to the right upper medial buttock was ordered on 3/6/24 and to start on 3/8/24. An order for skin prep to the left lateral ankle was dated 3/6/24 and to start 3/8/24 (wound found 3/4/24). There were no treatment orders for the heel wound found 3/6/24 until 3/7/24.

The facility's 4/12/2021 Pressure Ulcer Prevention Policy showed interventions necessary to maintain skin integrity or promote healing will be incorporated into the plan of care based on each resident's individual needs and risks. This policy was less than a page and a half

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008007	A. BUILDING: _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BLUFF NURSING HOME	4401 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 7	S9999		

in length. Additional pressure injury policies and/or procedures was requested twice, and none was received.

The facility's 10/12/2023 Wound Treatment Management Policy showed wound treatments will be provided in accordance with physician's orders. In the absence of treatment orders, the licensed nurse will notify the physician to obtain treatment orders. Treatments will be documented on the Treatment Administration Record or in the electronic health record.

R117's 2/9/24 pressure injury risk assessment showed he was bedfast and completely immobile (does not make even slight changes in body or extremity position without assistance).

R117's care plan showed impaired mobility related to cognitive loss, incontinence, pain, visual deficit, inconsistent motivation to participate in his care, and required hands on assist with repeated verbal directions to participate in and to complete bed mobility and repositioning. R117's care plan showed he required assistance from 2 staff members using a total mechanical lift for all transfers, was non-weight bearing and non-ambulatory. R117's 2/9/24 care plan showed a closed right hip fracture related to a fall. The 2/16/24 potential for pressure development related to decreased mobility care plan was updated 3/4/24 to show 2 new bilateral heel deep tissue injuries. Interventions dated 3/5/24 showed to apply heel lift boots and off load heels while in bed.

R117's 2/15/24 facility assessment showed severe cognitive impairment and bilateral lower extremity range of motion impairment. This assessment showed dependence for toileting,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008007	A. BUILDING: _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BLUFF NURSING HOME	4401 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 8	S9999		

bathing, lower body dressing, putting on and taking off footwear, roll left and right, sit to lying, and lying to sitting on side of bed.

(B)
Statement of Licensure Violations 3 of 3:
300.610a)
300.1010h)
300.1210b)
300.1210c)
300.1210d)3)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008007	A. BUILDING: _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BLUFF NURSING HOME	4401 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 9	S9999		

of notification.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

These Regulations are not met as evidenced by:

Based on observation, interview, and record review the facility failed to identify decreased food intake for residents and implement interventions to prevent a significant weight loss for 2 of 6 residents (R50 & R87) reviewed for nutrition in the sample of 31.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008007	A. BUILDING: _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BLUFF NURSING HOME	4401 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 10	S9999		

These failures resulted in a 5% weight loss in one month for R50 and R87.

The findings include:

1. On 3/5/24 at 10:03 AM, R50 was in bed with the head of her bed raised. R50 had her tray table in front of her with her breakfast tray sitting on it. R50 had a sausage patty, hardboiled egg, roll, french toast, water, and chocolate milk. The french toast was cut in half and did not have any syrup on it. R50 picked up the hardboiled egg, looked at it and sat it back down on the tray table. R50 did not eat any of her breakfast. R50 was talking gibberish to herself and when asked questions. No staff were observed assisting R50 with breakfast.

On 3/5/24 at 1:06 PM, R50 was sitting in her bed with the head of her bed elevated. R50 had her tray table in front of her with her lunch sitting on it. R50 had au gratin potatoes, broccoli, cake, beef a Roni, water, and juice. R50 did not eat any of her food; lunch was served at around 12:15 PM. R25 CNA (Certified Nursing Assistant) came into the room to assist R50's roommate and stated R50 hasn't been eating but will drink her fluids and then left the room.

The Care Plan dated 2/7/24 for R50 showed, R50 has an ADL (activity of daily living) self-care performance deficit related to cognitive loss, episodes of impaired balance, resistive with staff during care, bi-lateral lower extremity edema, incontinence, alteration in endurance, new to facility, and requires repeated verbal directions, coaxing, encouragement and hands on assist to participate in and to complete daily care and tasks. Eating: R50 is able to feed herself after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008007	A. BUILDING: _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BLUFF NURSING HOME	4401 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 11	S9999		

staff assist with set up of meal. Provide finger foods when R50 has difficulty using utensils. Provide milkshakes or liquid food supplements when R50 refuses or has difficulty with solid food or provide nutritious foods that can be taken from a cup or a mug where appropriate. R50 has potential nutritional problem. Provide, serve diet as ordered. Monitor intake and record every meal. Registered dietician to evaluate and make diet change recommendations as needed.

The Nutrition/Dietary Note dated 2/15/24 for R50 showed, Diet: Regular with regular texture and thin liquids. Per Nursing notes, resident requires cues and intermittent 1:1 assist to stay on task with meals.

The weights for R50 documented in the electronic medical record as of 3/6/24 showed on 2/1/24 her weight was 163. 4 pounds and on 3/1/24 her weight was 152.4 pounds. R50 had an 11-pound weight loss in one month = 6.7% weight loss.

On 3/6/24 at 3:30 PM, V40 RN (Registered Nurse/Unit Coordinator) stated, significant weight changes come up in the weights section of the computer charting. V40 stated they meet every Thursday for a meeting to discuss weight changes. V40 stated she did want to get a re-weigh for R50 to see if the weight was accurate. V40 stated if there was a weight loss the doctor and power of attorney would be notified. V40 stated she would discuss the weight change with the registered dietician, and she will see the resident and make recommendations. V40 stated she believes R50's weight is accurate because she looks like she has lost some weight. Staff should be encouraging her to eat. V40 stated she thinks R50 might be needing more help and that it hasn't been brought to her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008007	A. BUILDING: _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BLUFF NURSING HOME	4401 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 12	S9999		

attention yet by staff. V40 stated if a resident refuses to eat staff can offer a supplement, come back later, and try to get the resident to eat, and try to find out why the resident is not eating. V40 stated that no one has said anything to her about R50 not eating.

On 3/7/24 at 8:37 AM, V23 CNA (Certified Nursing Assistant) stated, if the resident is not eating, we will let the nurse know. We assist if they need help eating. If not eating with assistance, then let nurse know. V23 stated she would offer the resident something else like fruit or if they can tell her what they want she will get that. V23 stated they can offer supplement shakes. V23 stated if there were a big weight change for a resident, she would let the nurse know.

On 3/7/24 at 9:18 AM, V20 RD (Registered Dietician) stated she is at the facility 8 times per month so usually twice per week on Mondays and Thursdays. V20 stated she was on vacation and had V21 RD filling in for her remotely this last Monday. V20 stated she typically is the one that goes through the weights to look for weight changes. V20 stated the facility has weekly weight meetings and will bring stuff to her attention as well. V20 stated she printed off a list of residents and weight concerns from home and circled the residents that she needs reweighs on and have questions about. V20 stated she would talk to the unit coordinator to see if they thought the weights in question were legitimate or not. V20 stated V21 listed R50 as needing to be re-weighed on Monday (3/4/24) to make sure the weight was accurate. As of last night (3/6/24) she did not see that R50 had been reweighed. V20 stated typically when she asks for a reweigh, she would have to wait for the new weight to know if it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008007	A. BUILDING: _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BLUFF NURSING HOME	4401 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13	S9999		

is accurate before she makes recommendations. V20 stated if the reweigh is not in there then apparently nothing was done. V20 stated she would have looked through R50's notes to see if she was refusing to eat and/or not feeding herself. If R50 was not feeding herself then staff could assist her. Staff could do verbal cueing. V20 stated she would expect a note in R50's chart saying she prefers liquids over food. V20 stated if the staff know R50 is declining in eating then they should be there to assist the resident with eating and verbal cues. V20 stated R50 eating in her room alone would not be good; it would be better to be out at a table.

The Nutrition/Dietary Note dated 3/7/24 at 9:49 AM for R50 showed, RD Weight Review; Principal diagnosis: unspecified dementia, severe, with other behavioral disturbances. Comfort care in place & do not hospitalize per family preference. Notified of reweigh per unit coordinator of 154.2#. Weight reflecting a significant weight loss of 5.6% (9.2 pounds) x/times 30 days. Meal intake remains variable, however, appears to have declined. Per records, resident requires cues and intermittent 1:1 assist to stay on task with meals. Noted Resident was fed per staff times 1 meal on 2/10, 2/17, 2/18, 2/29 & 3/2 per records. No labs to review. Discussed weight loss with unit coordinator and she will notify the power of attorney and primary care physician. Unit coordinator reports resident likes milk and has been taking fluids well. Will recommend supplement shakes twice a day to assist with calorie & protein needs. Monitor acceptance of supplement. Continue to cue & assist resident at meals as needed. Recommend weekly weight monitoring. Monitor intake & weight.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008007	A. BUILDING: _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BLUFF NURSING HOME	4401 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 14	S9999		

The Face Sheet dated 3/8/24 for R50 showed medical diagnoses including unspecified dementia, severe, with other behavioral disturbance, macular degeneration, history of anxiety disorder, hypertension, unspecified psychosis, polyneuropathy, hypothyroidism, hypercholesterolemia, vitamin D deficiency, and gastroesophageal reflux disease.

2. The Weights and Vitals Summary Sheet dated 3/7/24 for R87 showed on 2/1/24 his weight was 202.6 pounds and on 3/1/24 his weight was 186 pounds. R87 had a significant weight loss of 16.6 pounds in one month that equals and 8.2% weight loss.

The Face Sheet dated 3/7/24 for R87 showed diagnoses including alzheimer's disease, muscle weakness, protein-calorie malnutrition, generalized arthritis, hypertension, vitamin D deficiency, mixed hyperlipidemia, bilateral hearing loss, atherosclerotic heart disease, paroxysmal atrial fibrillation, cerebrovascular disease, gastro-esophageal reflux disease, benign prostatic hyperplasia, and type 2 diabetes mellitus.

The Progress Notes from 2/1/24 through 3/7/24 at 8:57 AM did not show any documentation related to R87's weight loss.

The Nutrition Intake Documentation for R87 from 2/7/24 through 3/6/24 showed staff documented the resident ate 76-100% of his meals except for 3 meals where he ate 51-75%.

On 3/7/24 at 8:41 AM, R22 LPN (Licensed Practical Nurse) reviewed R87's weights in the electronic medical record and stated usually when the weight loss is like R87's the dietician will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008007	A. BUILDING: _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BLUFF NURSING HOME	4401 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 15	S9999		

come in and see the resident, have the resident re-weighed and go from there. R22 stated R87 eats really well and usually has a weight gain. R22 stated she was not aware of R87's weight loss and would have him re-weighed.

On 3/7/24 at 8:59 AM, V3 RN (Registered Nurse/Unit Coordinator) stated they have meetings every week about weights. V3 stated that the dietician was on vacation. V3 reviewed R87's weight in the computer and stated he is going to have R87 re-weighed because doesn't think the weight is accurate. V3 stated R87 usually eats great and has no eating problems that he is aware of. V3 stated the dietician goes through the building. There is a meeting that the unit coordinators go to, to talk about weight losses and gains. They re-weigh residents if needed. V3 stated if the documented weight is something ridiculous then it is brought to his attention. V3 stated R87's weight loss was kind of ridiculous.

The Weights and Vitals Summary Sheet dated 3/7/24 for R87 showed at 10:56 AM he was re-weighed, and his weight was 186.4 which was a 16.2-pound weight loss. This was an 8% significant weight loss in one month from his 2/1/24 weight of 202.6 pounds.

The Care Plan dated 1/25/24 for R87 showed R87 is able to feed himself independently, staff assist with set up as and if needed. R87 has a potential nutritional problem related to his weight being higher than recommended for his height. Monitor intake and weight. Monitor/record/report as needed any signs/symptoms of malnutrition: emaciation (cachexia), muscle wasting, significant weight loss: 3 pounds in 1 week, >5% in 1 month, >7.5% in 3 months, and >10% in 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008007	A. BUILDING: _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BLUFF NURSING HOME	4401 NORTH MAIN STREET ROCKFORD, IL 61103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 16	S9999		

months.

The Nutritional Management policy (10/12/23) showed, the facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall condition. A systematic approach is used to optimize each resident's nutritional status: a. Identifying and assessing each resident's nutritional status and risk factors; b. Evaluating/analyzing the assessment information; c. Developing and consistently implementing pertinent approaches; d. Monitoring the effectiveness of interventions and revising them as necessary. A comprehensive nutritional assessment will be completed by a dietician within 72 hours of admission, annually, and upon significant change in condition. Care Plan implementation: Interventions will be individualized to address specific needs of resident. Examples include but are not limited to iii. Weight related interventions; iv. Environmental interventions; vi. Physical assistance or provision of assistive devices. The physician will be notified of i. significant changes in weight, intake, or nutritional status.... Nutritional recommendations may be made by dietician based on resident's preferences, goals, clinical condition, or other factors and followed up with the physician/practitioner for orders as per facility policy, if indicated.

(B)